PPIC®
The link between coverage and caring®

December 17, 2010

Gayle Neuman
Illinois Department of Insurance
320 W. Washington Street
Springfield, IL 62767-0001

RE: Preferred Professional Insurance Company (PPIC) 47-0580977
NAIC #36234
Medical Malpractice Rule Filing RATE/RULE PHYSICIANS/SURGEONS
PPIC Filing No. IL-PS-10-03

Dear Ms. Neuman:

This letter and the enclosed material are being submitted on behalf of Preferred Professional Insurance Company® (PPIC®) to be effective January 1, 2011 for new and renewal business in Illinois.

PPIC is filing a revision to page 11 of our PPIC Underwriting Guidelines rule manual. Item F has been deleted and the edition date has been changed from 1/1/2009 to 12/14/2010. I have included a side-by-side comparison for your review.

Also enclosed are certifications from a company officer and actuary certifying that PPIC's rates are based on sound actuarial principles and are not inconsistent with PPIC's experience. Finally, I have enclosed our Property & Casualty Transmittal Document and a complete copy of the revised PPIC Underwriting Guidelines.

I am certifying that nothing has changed from the previously filed PPIC Underwriting Guidelines manual, which was approved effective 1/1/2009, except for what is highlighted in this filing.

Please note that PPIC uses ISO as our statistical agent.

If you should have any questions or require additional information, you may contact me via telephone (800) 441-7742, Ext. 3233 or at the following email address: ssnyder@ppicins.com. Thank you for your continued consideration of our filing.

Sincerely,

Suni Snyder

Suni M. Snyder
Corporate Compliance Paralegal

Enclosures

I-O
MEM
RUL
alm
Jeh

Preferred Professional Insurance Company®
11605 Miracle Hills Drive
Suite 200
Omaha, NE 68154-4467
Tel 402.392.1566
Fax 402.392.2673
www.ppicins.com

Dedicated to enhancing Catholic health care by being a unique insurance resource for health care providers.

Effective January 1, 2009

Property & Casualty Transmittal Document

Reset Form

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only
	a. Date the filing is received: RECEIVED
	b. Analyst:
	c. Disposition:
	d. Date of disposition of the filing: DEC 20 2010
	e. Effective date of filing:
	New Business
	Renewal Business
	f. State Filing #: STATE OF ILLINOIS DEPARTMENT OF INSURANCE SPRINGFIELD
	g. SERFF Filing #:
	h. Subject Codes

3.	Group Name	Group NAIC #

4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	Preferred Professional Insurance Company	NE	36234	47-0580977	N/A

5.	Company Tracking Number	IL-PS-10-03

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Suni Snyder	Paralegal	800-441-7742	402-392-2673	ssnyder@ppicins.com
	11605 Miracle Hills Drive, Suite 200 Omaha, NE 68154				
7.	Signature of authorized filer		Suni Snyder		
8.	Please print name of authorized filer		Suni Snyder		

Filing information (see General Instructions for descriptions of these fields)

9.	**Type of Insurance (TOI)**	11.2 Med Mal-Claims Made Only
10.	**Sub-Type of Insurance (Sub-TOI)**	11.2023 Physicians & Surgeons
11.	**State Specific Product code(s)(if applicable)[See State Specific Requirements]**	
12.	**Company Program Title** (Marketing title)	Physicians & Surgeons Professional Liability
13.	**Filing Type**	☐ Rate/Loss Cost ☑ Rules ☐ Rates/Rules ☐ Forms ☐ Combination Rates/Rules/Forms ☐ Withdrawal ☐ Other (give description)
14.	**Effective Date(s) Requested**	New: 01/01/2011 Renewal: 01/01/2011
15.	**Reference Filing?**	☐ Yes ☑ No
16.	**Reference Organization** (if applicable)	N/A
17.	**Reference Organization # & Title**	N/A
18.	**Company's Date of Filing**	December 17, 2010
19.	**Status of filing in domicile**	☐ Not Filed ☐ Pending ☑ Authorized ☐ Disapproved

Property & Casualty Transmittal Document—

20.	This filing transmittal is part of Company Tracking #	IL-PS-10-03

21.	Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

This letter and the enclosed material are being submitted on behalf of Preferred Professional Insurance Company® (PPIC®) to be effective January 1, 2011 for new and renewal business in Illinois.

PPIC is filing a revision to page 11 of the PPIC Underwriting Guidelines rule manual. Item F has been deleted and the edition date has been changed from 01/01/2009 to 12/14/2010.

Thank you for your consideration of our filing.

View Complete Filing Description

22.	Filing Fees (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: N/A
Amount: N/A

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	IL-PS-10-03

2.	**This filing corresponds to form filing number** (Company tracking number of form filing, if applicable)	

☐ Rate Increase ☐ Rate Decrease ☐ Rate Neutral (0%)

3.	**Filing Method (Prior Approval, File & Use, Flex Band, etc.)**	Use & File

4a. Rate Change by Company (As Proposed)

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)

4b. Rate Change by Company (As Accepted) For State Use Only

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)

		COMPANY USE	STATE USE
5a	Overall percentage rate indication (when applicable)		
5b	Overall percentage rate impact for this filing		
5c	Effect of Rate Filing – Written premium change for this program		
5d	Effect of Rate Filing – Number of policyholders affected		

6.	Overall percentage of last rate revision	
7.	Effective Date of last rate revision	
8.	Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)	

9.	Rule # or Page # Submitted for Review	Replacement or withdrawn?	Previous state filing number, if required by state
01	Guideline #UW-10, Page 11	☐ New ☑ Replacement ☐ Withdrawn	
02		☐ New ☐ Replacement ☐ Withdrawn	
03		☐ New ☐ Replacement ☐ Withdrawn	

CERTIFICATION

Pursuant to Section 215, ILCS 5/155.18 of the Illinois Insurance Code, I, Bryan G. Young, FCAS, MAAA, Towers Watson, do hereby certify that the Physicians and Surgeons claims Made existing rates on file for the State of Illinois are based on sound actuarial principles and are not inconsistent with Preferred Professional Insurance Company's experience.

In Witness Whereof, I have hereunto set my hand this **16th** *of* **December** *, 20* **10** .

Bryan G. Young, FCAS, MAAA
Actuarial Consultant
Towers Watson

STATE OF **Georgia**
COUNTY OF **Cobb**

On this **16th** *day of* **December** *, 20* **10** *, Bryan Young appeared before me, a Notary Public, and being duly sworn, says that he has read the foregoing statement, and that the statement is true to his best knowledge.*

Notary Public Susan L. Higgins
Notary Signature

NOTARY SEAL

My Commission Expires: March 30, 2014

CERTIFICATION

Pursuant to Section 215, ILCS 5/155.18 of the Illinois Insurance Code, I, Denise A. Hill,, VP, Corporate Compliance Officer, General Counsel, of Preferred Professional Insurance Company (PPIC), do hereby certify that the Physicians and Surgeons claims Made existing rates on file for the State of Illinois are based on sound actuarial principles and are not inconsistent with Preferred Professional Insurance Company's experience.

In Witness Whereof, I have hereunto set my hand this **15th** *of* **December** *, 20* **10** *.*

Denise A. Hill
SVP, Corporate Compliance Officer, General Counsel
Preferred Professional Insurance Company

STATE OF **Nebraska**
COUNTY OF **Douglas**

On this **15th** *day of* **December** *, 20* **10** *, Denise A. Hill appeared before me, a Notary Public, and being duly sworn, says that he has read the foregoing statement, and that the statement is true to his best knowledge.*

Notary Public
Notary Signature

GENERAL NOTARY - State of Nebraska
DANA HENDERSON
My Comm. Exp. July 17, 2011

NOTARY SEAL

My Commission Expires: 7-17-11

Neuman, Gayle

From: Suni Snyder [ssnyder@ppicins.com]
Sent: Tuesday, December 21, 2010 10:24 AM
To: Neuman, Gayle
Subject: Preferred Professional Ins Co - Filing #IL-PS-10-03
Attachments: Withdrawl Letter 12-21-10.pdf

Good morning Ms. Neuman,

I mailed the above referenced filing to your attention on December 17, 2010. Preferred Professional Insurance Company would like to withdraw this filing. I have attached a withdrawl letter for your records.

Thank you,
Suni Snyder

Suni M. Snyder
Corporate Compliance Paralegal
Preferred Professional Insurance Company®
11605 Miracle Hills Drive
Suite 200
Omaha, NE 68154-4467
(402) 965-3233 direct line
(800) 441-7742 toll free
(402) 392-1566 general office
(402) 392-2673 fax
ssnyder@ppicins.com
www.ppicins.com -check out our new virtual classroom!

The link between coverage and caring®

December 21, 2010

Gayle Neuman
Illinois Division of Insurance
320 W. Washington Street
Springfield, IL 62767-0001

RE: Preferred Professional Insurance Company (PPIC)
NAIC #36234
Medical Malpractice Rule Filing
PPIC Filing No. IL-PS-10-03

Preferred Professional Insurance Company®
11605 Miracle Hills Drive
Suite 200
Omaha, NE 68154-4467
Tel 402.392.1566
Fax 402.392.2673
www.ppicins.com

Dear Ms. Neuman:

Thank you for your initial review of the above referenced filing. Please be advised that PPIC would like to withdraw this filing.

If you should have any questions, you may contact me via telephone (800) 441-7742, Ext. 3233 or at the following email address: ssnyder@ppicins.com. Thank you.

Sincerely,

Suni M. Snyder
Corporate Compliance Paralegal

Dedicated to enhancing Catholic health care by being a unique insurance resource for health care providers.

Previous Version

SUBJECT: EXTENDED REPORTING PERIOD COVERAGE – SLOT-RATED	
LINE OF COVERAGE: HEALTH CARE PROVIDER – CLAIMS MADE	
GUIDELINE NUMBER: UW-10	
EFFECTIVE DATE: 01/01/2009	REVISION DATE: ~~01/01/2009~~ 12/14/2010

A. A supplemental aggregate limit of liability is available for an extra premium charge. The supplemental aggregate limit of liability provided is equal to the limit of liability provided by the policy that the extended reporting endorsement is attached to.

B. A written request and payment for the extended reporting period coverage must be received in our office within 60 days of the termination of the policy.

C. Once in effect, an extended reporting period cannot be canceled. The premium is fully earned upon receipt.

D. The extended reporting period coverage may also be purchased by an individual health care provider while the policy is still in effect if the individual health care provider has properly withdrawn his/her coverage from the policy or the individual health care provider is filling a "slot" and the "slot" is closed during the policy period.

E. Extended reporting period coverage may be provided at no charge for the following reasons:

1. The death of the health care provider;
2. The health care provider becomes continuously and permanently disabled for 6 months and is unable to carry out his/her profession or practice as a physician, surgeon, dentist or other Health Care Provider.
3. The health care provider retires permanently from the profession or practice as a physician, surgeons, dentist, or other health care provider after accumulating five or more years of claims-made coverage from PPIC and attaining the age of 55.
4. The health care provider retires permanently as a result of suffering a terminal disease with no known cure.

This "no charge" extended reporting period does not reinstate or increase the limits of insurance available. (If the insured desires a "new" supplemental aggregate limit of liability, this may be purchased. See item A above.)

~~F. Any credit or debit applied to the policy premium will also apply to the extended reporting period premium.~~

G. For an extended reporting period, ERP factors are based on expiring annual premium. ERP factors are:

1st year claims made:	2.28
2nd year claims made:	2.00
3rd year claims made:	1.82
4th year claims made:	1.77
5th year claims made:	1.63

ERP premiums are prorated.

The anticipated ERP premium will be shared with the insured at policy inception and at the time the last policy is purchased (renewal notice).

New Version

SUBJECT: EXTENDED REPORTING PERIOD COVERAGE – SLOT RATED	
LINE OF COVERAGE: HEALTH CARE PROVIDER – CLAIMS MADE	
GUIDELINE NUMBER: UW-10	
EFFECTIVE DATE: 01/01/2009	REVISION DATE: 12/14/2010

A. A supplemental aggregate limit of liability is available for an extra premium charge. The supplemental aggregate limit of liability provided is equal to the limit of liability provided by the policy that the extended reporting endorsement is attached to.

B. A written request and payment for the extended reporting period coverage must be received in our office within 60 days of the termination of the policy.

C. Once in effect, an extended reporting period cannot be canceled. The premium is fully earned upon receipt.

D. The extended reporting period coverage may also be purchased by an individual health care provider while the policy is still in effect if the individual health care provider has properly withdrawn his/her coverage from the policy or the individual health care provider is filling a "slot" and the "slot" is closed during the policy period.

E. Extended reporting period coverage may be provided at no charge for the following reasons:

1. The death of the health care provider;
2. The health care provider becomes continuously and permanently disabled for 6 months and is unable to carry out his/her profession or practice as a physician, surgeon, dentist or other Health Care Provider.
3. The health care provider retires permanently from the profession or practice as a physician, surgeons, dentist, or other health care provider after accumulating five or more years of claims-made coverage from PPIC and attaining the age of 55.
4. The health care provider retires permanently as a result of suffering a terminal disease with no known cure.

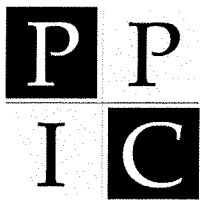
This "no charge" extended reporting period does not reinstate or increase the limits of insurance available. (If the insured desires a "new" supplemental aggregate limit of liability, this may be purchased. See item A above.)

F. For an extended reporting period, ERP factors are based on expiring annual premium. ERP factors are:

1st year claims made:	2.28
2nd year claims made:	2.00
3rd year claims made:	1.82
4th year claims made:	1.77
5th year claims made:	1.63

ERP premiums are prorated.

The anticipated ERP premium will be shared with the insured at policy inception and at the time the last policy is purchased (renewal notice).



The link between coverage and caring

PPIC
UNDERWRITING GUIDELINES

THESE ARE GUIDELINES ONLY. PPIC's general underwriting principles and criteria are described in the following pages. However, in no sense is this intended to be a totally comprehensive list of every consideration that may be used in arriving at any particular underwriting decision.

INDEX

These guidelines may be affected by individual state requirements. Refer to the specific state filing manual or state mandated endorsement for details.

SUBJECT: COMPANY MISSION	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-01	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

COMPANY MISSION

The vision for the combined organization is to support the Catholic Health Ministry of its owners and other Catholic Healthcare providers by providing a wide array of insurance products and related services at a fair market price to its owners and to insureds who maintain a relationship with Catholic Healthcare Providers. The organization will make available a complete portfolio of insurance products and services, including a full range of primary and excess liability coverages for physicians, hospitals and other healthcare providers, Workers' Compensation and related coverages, fronting programs, and Third Party Administration services such as Claims and Risk Management.

SUBJECT: UNDERWRITING PHILOSOPHY	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-02	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. The basis of PPIC underwriting functions is economic. All underwriting decisions are in response to PPIC's determination of the potential for profit or loss.

B. All risks that meet eligibility requirements will be considered for acceptance on a fair, equitable, and consistent basis. PPIC is not obligated to provide coverage to any health care provider.

C. PPIC will perform all underwriting functions using professional standards designed to avoid criticism of the company, its employees, or owners.

D. All information obtained by PPIC will be held in confidence and used for underwriting purposes only. Any request for information from our underwriting files will be honored only with the written permission of the insured health care provider.

SUBJECT: RESPONSIBILITIES	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-03	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. PPIC Board of Directors. The ultimate responsibility to PPIC policyholders for the manner and quality of underwriting as performed on behalf of PPIC rests with the PPIC Board of Directors.

B. PPIC Underwriting Committee. The Board of Directors has delegated to its Underwriting Committee the responsibility for the development of the Company's underwriting philosophy, guidelines, and procedures, subject to Board approval. The Committee will also act as an appeal board for those health care providers wishing to appeal adverse decisions.

C. Management of PPIC. The President and Underwriting staff of PPIC have the responsibility to refine procedures and implement the underwriting guidelines as developed by the Underwriting Committee and approved by the Board of Directors.

SUBJECT: SOURCES OF INFORMATION	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-04	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A) Any or all of the following potential sources of information may be used in determining the acceptability of a physician:

1. Application
2. Applicant or Insured
3. PPIC Claims Department
4. PPIC Risk Management Department
5. Prior Insurers
6. State Department of Licensing and Regulation
7. Other Physicians
8. Hospitals, Hospital Administrators
9. Peer Review and Credentialing Data
10. Any Appropriate Medical Societies
11. Newspapers, Magazines, Radio, Television

B) The National Practitioner Data Bank may not be accessed.

SUBJECT: RISK MANAGEMENT	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-05	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

1) Refer to Risk Management for program details.
2) The Risk Management program is an option available to full time health care providers to earn a discount on their premium. A premium discount is available to health care providers who participate.
3) The premium discount is separate from the individual risk modification shown on guideline UW-25.
4) The premium discount given is based on a calendar year from January 1st to December 31st. The discount is applied to the renewal policy of the insured. If the insured does not renew with PPIC, no discount is allowed.
5) As renewal policies are processed before the risk management discount is known, the discount will be applied to the 2nd quarterly billing, due April 1st. At the April 1st billing, 50% of the discount will be credited, with 25% of the discount applied at the July 1st and the October 1st installment.
6) For those insureds who pay annually, a refund will be sent by April 1st.
7) The premium discount is applied to the extended reporting period premium in the event of cancellation.
8) Risk management discounts do not affect state funds, except for Nebraska. See Underwriting for details on Nebraska.

SUBJECT: INSURED QUALIFICATIONS	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-06	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Must hold unrestricted license to practice in the applicable jurisdiction.

B. Must have an appropriate percentage of his/her practice with the sponsoring hospital. Must do enough "work" at a member institution to take advantage of and participate in Risk Management/Quality Assurance program.

C. Must be Board Certified*, or in the certification process in his/her field or practice or demonstrate equivalents competency if performing surgical specialties, anesthesiology, emergency medicine, or other recognized specialties.

D. Must not perform procedures for which he/she has not been adequately trained, or practice beyond current abilities.

E. Must cooperate with PPIC and have cooperated with previous professional liability carriers in the handling of claims.

F. Should not have a history of mental illness, or physician disability (such as alcohol or drug abuse), without proof the problem no longer exists.

G. Should not have been cancelled or non-renewed by his/her current carrier. (Not applicable if carrier withdrew from market).

H. Should have current insurance coverage.

I. Must not have been the subject of any reprimand, suspension, or any other disciplinary actions by any hospital, medical society, or specialty society that would cause PPIC to question the applicant's medical competence or medical judgment.

J. Should have membership in appropriate medical societies.

K. Should not create an unnecessary exposure to PPIC because of unusual or experimental procedures.

L. Must obtain appropriate informed consent for care or procedures performed.

M. Must keep and maintain adequate and legible medical records for all patients.

N. Must not employ abusive or otherwise inappropriate bill collecting procedures.

O. Must not have an unusually large number of dissatisfied patients, as evidenced by a frequency or lawsuits regardless of the merit of the lawsuit.

P. Must adhere to the Ethical and Religious Directives for Catholic Health Facilities at member facilities.

SUBJECT: INSURED QUALIFICATIONS	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-06	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

Q. Should not perform or participate in:

1. Office cosmetic surgery
2. Weight control by use of drugs
3. Weight control by use of surgical operations
4. Convulsive shock therapy
5. Injection of silicones
6. Sex change surgery

Refer all requests for exception to Vice President of Underwriting.

* See Guideline #UW-33 regarding emergency medicine health care providers.

SUBJECT: NEW BUSINESS AND RENEWAL SUBMISSIONS	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-07	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. No coverage may be bound or issued until approved by the Underwriting Department of PPIC at its home office in Omaha, Nebraska.

B. A fully completed application, signed by the applicant, must be submitted before any underwriting decision will be made.

C. If approved by PPIC, coverage will be bound on the date following postmark or the effective date shown on the application, whichever is later, if a deposit premium of $500 or policy premium, whichever is less accompanies the application.

D. Prior acts coverage may be provided in accordance with the policy terms. See guideline UW-21

E. If no deposit premium is paid, coverage may not be bound until the premium (deposit or quarterly) is received by PPIC. This provision may be waived if applicant is joining an existing PPIC insured group.

F. Renewal questionnaires will be sent to the insured 60 days before policy expiration. It **must** be completed, signed and returned before a renewal policy will be issued.

SUBJECT: PREMIUM PAYMENTS	
LINE OF COVERAGE: HEALTH CARE PROVIDERS – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-08	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

A. Premium may be paid annually or quarterly, with no interest or installment charge. Quarterly premiums require an initial deposit of 25% of the total premium at inception. The remaining premium will be spread equally among the 2nd, 3rd and 4th installments. Installment billing dates are January 1, April 1, July 1, and October 1. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

B. If the full annual premium is paid in advance, a 2% premium reduction will be applied. (Applicable in states where filed and approved only)

SUBJECT: EXTENDED REPORTING PERIOD COVERAGE (ERP) – NON-SLOT-RATED	
LINE OF COVERAGE: HEALTH CARE PROVIDER – CLAIMS MADE	
GUIDELINE NUMBER: UW-09	
EFFECTIVE DATE: 01/01/2009	REVISION DATE: 11/01/2009

A. A supplemental aggregate limit of liability is available for an extra premium charge. The supplemental aggregate limit of liability provided is equal to the limit of liability provided by the policy that the extended reporting endorsement is attached to.

B. An extended reporting period of unlimited duration will be offered when a policy is cancelled or nonrenewed for any reason, including nonpayment of premium, and whether the policy is cancelled by the company or at the insured's request. A written request and payment for the extended reporting period coverage must be received in our office within 60 days of the termination of the policy.

C. Once in effect, an extended reporting period cannot be cancelled. The premium is fully earned upon receipt.

D. Extended reporting period coverage may be provided at no charge for the following reasons:

1. The death of the health care provider;
2. The health care provider becomes continuously and permanently disabled and is unable to carry out his/her profession or practice as a physician, surgeon, dentist or other Health Care Provider.
3. The health care provider retires permanently from the profession or practice as a physician, surgeons, dentist, or other health care provider after accumulating five or more years of claims-made coverage from PPIC.
4. The health care provider retires permanently as a result of suffering a terminal disease with no known cure.

This "no charge" extended reporting period does not reinstate or increase the limits of insurance available. (If the insured desires a "new" supplemental aggregate limit of liability, this may be purchased. See item A above.)

E. Unless otherwise specified, miscellaneous professional employee's share in the limits purchased for the corporation, if any. No additional charge is made for miscellaneous professional employees.

F. Any credit or debit applied to the policy premium will also apply to the extended reporting period.

G. For an extended reporting period, ERP factors are based on expiring annual premium. ERP factors are:

1st year claims made:	2.28
2nd year claims made:	2.00
3rd year claims made:	1.82
4th year claims made:	1.77
5th year claims made:	1.63

ERP premiums are prorated.

The anticipated ERP premium will be shared with the insured at policy inception and at the time the last policy is purchased (renewal notice).

SUBJECT: EXTENDED REPORTING PERIOD COVERAGE – SLOT-RATED	
LINE OF COVERAGE: HEALTH CARE PROVIDER – CLAIMS MADE	
GUIDELINE NUMBER: UW-10	
EFFECTIVE DATE: 01/01/2009	REVISION DATE: 12/14/2010

A. A supplemental aggregate limit of liability is available for an extra premium charge. The supplemental aggregate limit of liability provided is equal to the limit of liability provided by the policy that the extended reporting endorsement is attached to.

B. A written request and payment for the extended reporting period coverage must be received in our office within 60 days of the termination of the policy.

C. Once in effect, an extended reporting period cannot be canceled. The premium is fully earned upon receipt.

D. The extended reporting period coverage may also be purchased by an individual health care provider while the policy is still in effect if the individual health care provider has properly withdrawn his/her coverage from the policy or the individual health care provider is filling a "slot" and the "slot" is closed during the policy period.

E. Extended reporting period coverage may be provided at no charge for the following reasons:

1. The death of the health care provider;
2. The health care provider becomes continuously and permanently disabled for 6 months and is unable to carry out his/her profession or practice as a physician, surgeon, dentist or other Health Care Provider.
3. The health care provider retires permanently from the profession or practice as a physician, surgeons, dentist, or other health care provider after accumulating five or more years of claims-made coverage from PPIC and attaining the age of 55.
4. The health care provider retires permanently as a result of suffering a terminal disease with no known cure.

This "no charge" extended reporting period does not reinstate or increase the limits of insurance available. (If the insured desires a "new" supplemental aggregate limit of liability, this may be purchased. See item A above.)

F. For an extended reporting period, ERP factors are based on expiring annual premium. ERP factors are:

1st year claims made:	2.28
2nd year claims made:	2.00
3rd year claims made:	1.82
4th year claims made:	1.77
5th year claims made:	1.63

ERP premiums are prorated.

The anticipated ERP premium will be shared with the insured at policy inception and at the time the last policy is purchased (renewal notice).

SUBJECT: EXTENDED REPORTING PERIOD COVERAGE – PARTNERSHIP, LIMITED LIABILITY COMPANY, CORPORATION	
LINE OF COVERAGE: ALL LINES – CLAIMS MADE	
GUIDELINE NUMBER: UW-11	
EFFECTIVE DATE: 07/01/99	REVISION DATE: 07/01/99

A. Should an individual named insured terminate association with a partnership or corporation, extended reporting period coverage can be provided to the partnership or corporation if the following criteria is met:
   1) The partnership or corporation is insured with PPIC.
   2) The individual named insured has purchased extended reporting period coverage on their individual policy or has purchased prior acts coverage with the new carrier (proof of coverage is required). Each individual named insured who terminated their association with the partnership or corporation has purchased extended reporting period coverage.
   3) Each individual named insured who terminated their association with the partnership or corporation has purchased extended reporting period coverage.

B. If all members of an entity purchase tail coverage, the entity shall then be entitled to purchase tail coverage.

SUBJECT: POLICY PERIOD	
LINE OF COVERAGE: HEALTH CARE PROVIDERS – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-12	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. All health care provider policies are issued for a period of one year or less and have a common renewal date of January 1st.

B. All new policies will be pro-rated to expire on January 1st.

C. All rate increases will take effect on January 1st for renewal policies.

D. All "step increases" will take effect on the original anniversary date of the policy, with the premium spread equally over the year. (Pro rate "step" (x) plus "step" (x+1)).

EXAMPLE:

Effective date of coverage = 5/1/1989
Effective date of policy = 5/1/1989
Expiration date of policy = 1/1/1990

Annual premium = $12,000 (step x)
Renewal premium = $18,000 (step (x+1))

5/1/1989 to 1/1/1990

Policy premium = $12,000 x .671 (prorate) = $8,052

1/1/1990 to 1/1/1991

$12,000 x (.329) = $3,948 + $18,000 x (.671) = $12,078

Policy premium = $ 3,948 (step x)
+ $12,078 (step (x+1))
$16,026

SUBJECT: CALCULATION OF PREMIUM & MINIMUM PREMIUM	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-13	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. The initial premium shall be determined on the basis of the health care provider's specialty being practiced at policy inception. All premiums are subject to audit, and premium may be adjusted based on the audit.

B. The premium on policies written for a period of less than one year shall be computed on a prorata basis.

C. Subject to the calculation of premium procedures described above, no health care provider professional liability policy will be issued for a premium charge of less than $100.

D. Additional or return premium of $25.00 or less will be waived. Return premium will be allowed when requested by the insured.

E. Policy changes requiring additional premium will be computed on a prorata basis. The rules and rates in effect at the time of the change will be used to calculate any additional premium.

F. Policy changes (excluding cancellation) requiring return premium will be computed on a prorata basis. The original rates used to calculate the policy premium will be used to compute the return premium.

G. If an extended reporting period endorsement is issued, it is subject to a separate $100 minimum premium.

SUBJECT: CANCELLATION – NONRENEWAL	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-14	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. The earned premium will be determined on a short rate basis (.90 of the prorata unearned premium) for the period the policy was in force if the insured cancels.

B. The earned premium will be determined on a prorata for the period the policy was in force if the company cancels.

C. If the insured cancels on the same date as a quarterly premium installment due date and the insured is current in all payments due PPIC, the earned premium will be the same as the premium due up to that quarterly installment date.

D. The earned premium calculated will be subject to the Minimum Premium rule.

E. Extended reporting endorsements may not be canceled, and the premium is fully earned when received.

F. If the company cancels, notice will be sent in accordance with state requirements.

SUBJECT: LIMITS OF LIABILITY	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-15	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Manual rates provide the basis limit of liability indicated on the rate page. The limits apply separately to each covered person. When an organization is also covered, the limits may apply separately to that organization (for additional premium) or that organization may share the limits with the insured (at no increase in premium). This may not be applicable in "State Fund" states. See Underwriting Department for details.

B. All health care providers in the same organization must be written with equal limits of liability. The Vice President of Underwriting must approve any exception.

C. The only limits of liability available to a health care provider are those filed and approved in the state applicable to the exposure of the health care provider.

D. PPIC is unable to offer prior acts coverage or extended reporting period coverage at higher limits than those going forward. If the limits going forward are lower and acceptable to the insured for the prior acts coverage, a signed statement is required from the insured indicating their agreement to the limits of liability.

E. State fund states must carry a minimum level of limits of liability. For higher limits, refer to underwriting.

F. State fund states may have exceptions applicable to the Partnership, Limited Liability Company, Association or corporation professional liability coverage. Refer to Underwriting Department for details.

SUBJECT: PARTNERSHIP, LIMITED LIABILITY COMPANY, ASSOCIATION, OR CORPORATION	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-16	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. All health care providers who are partners, shareholders, officers, directors, or employees must be individually insured with PPIC. If the corporate entity is a group practice, all health care providers must transfer to PPIC at the renewal of their policy. Limits of liability for the partnership, Limited Liability Company, association or corporation must be equal to those carried by the health care providers.

B. An additional charge of 10% of the "per person" rate for each individual member (including employed) shall apply for all the classifications. The limit of liability provided is separate from the health care providers.

C. A medical corporation, limited liability company or association consisting of a single physician may be included as an additional insured under the sole shareholder physician's individual policy. The limits of liability are shared between the health care provider and the corporation, limited liability company or association. There is no additional premium for the shared limit. This may not be allowed in state fund states, refer to Underwriting Department.

SUBJECT: PREMIUM ADJUSTMENT FOR RISK CHANGE	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-17	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Health Care Providers changing their practice to a lower rated classification or rating territory continue to have an exposure to loss from their previous practice. To recognize this exposure change, the following procedure will be used and a one time premium adjustment will apply:

1. Determine current reporting endorsement premium from previous classification/rating territory $_____
2. Subtract current reporting endorsement premium from new classification/rating territory $_____
3. Difference will be premium adjustment $_____

B. The premium adjustment will be in addition to the premium for the new classification/rating territory. The insured original retroactive date will be maintained. Upon termination of the current policy or its renewal, the reporting endorsement premium applicable to the new classification/territory will apply.

C. Charge does not apply for a change in class if:

1. Both the previous class and current class are the same class, or
2. The specialty change occurred more than 5 years ago while insured under a claims made coverage (except for physicians having an obstetrical exposure, then a charge will apply).
3. The specialty change occurred while the doctor was insured under an occurrence policy.

D. Additional exposure for which coverage is provided on or after the effective date of a policy shall be written on the basis of the rates and rules in effect at the time the coverage is provided.

E. If the previous carrier has made a charge for the higher rated exposure, PPIC will still make a charge unless a certificate of insurance is obtained (and approved by PPIC) that the previous carrier is providing extended reporting period coverage on the higher rated exposure.

SUBJECT: LIMITS OF LIABILITY REDUCTION	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-18	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. When limits of liability are reduced on a policy of PPIC, extended reporting period coverage will be offered. If purchased, the previous limits will apply to incidents that occurred before the effective date of the change endorsement, subject to all other terms of the policy.

B. Limits of liability may not be increased for an extended reporting period endorsement. The limits shown on the last full term policy will be the only limits offered on the extended reporting period endorsement.

SUBJECT: PHYSICIANS AGE 70 OR OLDER	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-19	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Insured physicians wishing to continue practicing medicine following their 70th birthday will be required to have a complete physical examination done by an unrelated physician.

B. A family member or a physician in the same clinic as the insured physician may not do the examination.

C. The examination must indicate the insured physician is in good physical and mental health. Any negative result will be referred to the Underwriting Committee Chairperson for review and determination if coverage may be continued.

D. The cost of the examination will be the responsibility of the insured physician.

SUBJECT: PHYSICIANS LEAVING SPONSORING HOSPITAL	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-20	
EFFECTIVE DATE: 01/01/2009	REVISION DATE: 01/01/2009

A. If for any reason, other than death, disability, or retirement, a physician is no longer on staff of a sponsoring institution, the physician will lose eligibility to obtain coverage from PPIC.

B. The physician will be notified as soon as possible of nonrenewal or cancellation. PPIC will cooperate with the physician to allow a reasonable time for the physician to find replacement coverage.

C. Extended reporting period coverage will be offered in accordance with the policy provision.

D. State insurance laws will govern the use of this guideline.

SUBJECT: RETROACTIVE DATE	
LINE OF COVERAGE: HEALTH CARE PROVIDER – CLAIMS MADE	
GUIDELINE NUMBER: UW-21	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Once the retroactive date is established, it will not be advanced without the written consent of the insured. If advanced, "tail" coverage will be offered for the prior period.

B. Requests for a retroactive date prior to the first effective date will require underwriting approval. All known or pending claims will be excluded from the coverage offered.

C. Rates will be adjusted to the appropriate "year" in the claims made interim adjustments, or to the "mature" rate.

D. Health Care Providers who have moved from different rating territories, or who have changed their practice, and the requested retroactive date will include the exposure of their previous territory or previous higher rated practice, require the approval of the Underwriting Department. See guideline UW-17 for premium charge.
   1. If accepted by PPIC, a higher premium charge will be made.
   2. If PPIC is not a licensed carrier in the prior state, prior acts coverage is unavailable.
   3. If the prior state is a very high rated state, prior acts coverage is unavailable.
   4. If the health care provider spent 10 years or more in a different state, prior acts coverage is unavailable.

SUBJECT: CLASSIFICATION PROCEDURE/OTHER STATE	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-22	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Classification assignment for rating purposes shall be made on the basis of medical specialty and performance or nonperformance of medical procedures.

B. The initial basis of classification assignment shall be the physician's highest rated specialty, from which more than 9% of his/her practice is derived. (example – a general surgeon (class 5) does 25% vascular surgery (class 6), rate as class 6.)

C. Any surgeon who assists in surgery only (100% of their practice) shall be rated 80445 – Surgeon/Assisting Only (Class 4). This does not apply to neurosurgery.

D. The rates as shown in this manual contemplate the exposure as being derived from professional practice within the state. For those who derive part of their income from outside the state, the territory to be used for rating purposes shall be a "blend" of the rates for each territory using the following guidelines:

1.	9% or less	No change to the rating.
2.	10 – 50%	Use the percentage of the higher rated state(s) premium in relation to the lower rated state(s) times the percentage of practice in the higher rated state times the base state rates. (Example: Iowa rates are 20% higher than Nebraska. A NE physician derives 15% of his income from IA. .20 x .15 = .03 x the NE rates for the IA exposure
3.	51% or Greater	Rated at the highest rated territory.

4. If the physician practices in more than 2 states, refer to underwriting.

SUBJECT: NEWLY PRACTICING AND PART TIME PHYSICIANS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-23	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Newly practicing physicians. Physicians who have been in practice for less than 12 months following completion of medical training or retraining for a new medical specialty practice shall receive a premium discount. (Physician just leaving full time military practice shall be included.)
   1. Newly practicing going into "solo" practice – 50%
   2. Newly practicing going into "group" – 25%

B. Part time. Physicians whose clinical medical practice time does not exceed an average of 25 hours per week shall receive a premium discount:
   1. Less than 10 hours a week – 35% discount
   2. Less than 25 hours a week – 25% discount

SUBJECT: RESTRICTION AND/OR SUSPENSION OF COVERAGE	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-24	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Suspended coverage. Premiums will be prorated for physicians who are temporarily in a voluntary inactive practice status for more than 3 months. This could include:
   1. Pregnancy
   2. Military duties
   3. Missionary work outside the United States.

   The policy will be endorsed to exclude any medical incident occurring during the time of suspension.

B. Restrictions of coverage or increased rate. Policies may be issued with special restrictions or at increased premium if:
   1. the insured agrees;
   2. the policy could not be written otherwise;
   3. and in admitted states, a consent to rate filing is approved by the state regulators.

   In state fund states, this may not be allowed, refer to underwriting.

SUBJECT: INDIVIDUAL RISK MODIFICATION	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-25	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. An adjustment to the premium (maximum of +/- 25%) developed at inception may be allowed, based on:
   1. Unusual or difficult procedures/characteristics;
   2. Failure to comply with reasonable Risk Management recommendations (negative only);
   3. Prior claim history (viewed as a function of the effectiveness of loss control);
   4. Cooperation with sponsoring hospital;
   5. Collection procedures.

B. The risk management program is in addition to the credits shown above.

C. An adjustment to the premium (maximum of –20%) developed at inception may be allowed for a group of health care providers employed by a health care facility. The health care facility must be owned by one of PPIC's owners. If a group has qualified for this adjustment and the health care facility discontinues employing the group, the adjustment may continue for 3 years after the employment ends.

D. The adjustment to the premium available is dependent on individual state approval.

SUBJECT: VICARIOUS LIABILITY	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-26	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. The rate for employed or full time contract physicians or surgeons shall be 10% of the rate applicable for the employed physician or surgeon.

SUBJECT: HEALTH MAINTENANCE ORGANIZATIONS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-27	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Coverage for the vicarious liability of PPOs or HMOs arising out of professional services performed by contracting physicians shall be $0.20 per person enrolled. Code as 80999. Must be approved by Underwriting Department.

SUBJECT: CONTRACTUAL LIABILITY	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-28	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. The policy provides no coverage for contractual liability

B. Any contract must contain at minimum a mutual hold-harmless agreement. The health care provider cannot hold the PPO/HMO harmless for the PPO's/HMO's acts.

C. Coverage for liability of others assumed under contract by insured physicians and surgeons shall be submitted for rating. Code as 80999. Must be approved by the Underwriting Department.

SUBJECT: LOCUM TENENS COVERAGE	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-29	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Coverage for locum tenens physicians may be provided by adding the locum tenen physician to the insured physician's policy. Coverage should not normally be provided for a period exceeding 45 days.

B. If the locum tenen physician shares the limit of liability with the named insured, no additional premium will be charged. Code as 80179.

C. See Endorsement #PP-133 for terms and conditions.

D. An application must be completed and approved prior to implementing coverage. At each policy renewal a renewal questionnaire must be completed. PPIC may require updated information at any time if the locum tenen continues to work for the insured health care provider.

SUBJECT: DEPARTMENT HEADS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-30	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Completed application is required. Rate according to the following schedule:

Time involved in Patient Contact	Department Heads with Limited Clinical Duties % applied to Physician or Surgeon Rate
Less than 25%	50%
25% to 30%	55%
30% to 35%	60%
35% to 40%	65%
40% to 45%	70%
Over 45%	75%

SUBJECT: ORAL SURGEONS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-31	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Any dentist engaged in oral surgery or operative dentistry on patients rendered unconscious through the administering of any anesthesia or analgesia.

B. Rate as a Class 5, but code as 80210.

SUBJECT: EMERGENCY ROOM PHYSICIANS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-32	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. A physician specializing in the practice of emergency medicine must meet the following criteria:
   1. Have Board Certification in emergency medicine, or
   2. Have Board Certification in a primary care specialty (family practice or internal medicine) and have completed a course in ACLS, ATLS, and either PALS or APLS.

SUBJECT: RATES	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-33	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Rates apply on an individual insured basis and are available in the applicable state rate filing manual.

B. For risks not found in the Manual, or procedures or techniques not otherwise identified, defined, or classified, submit for rating.

C. Rates are for an annual period of time.

SUBJECT: DEDUCTIBLES	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-34	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

A. The following credits apply for the deductible indicated. To determine deductible premium, apply the following percentage to the 100/300 premium and deduct the result from the increased limit premium.

Deductible Applies to Indemnity Only — Credit

Deductible	Physician	Surgeon
$5,000/$15,000	5%	5%
$10,000/$30,000	10%	10%
$25,000/$75,000	20%	18%
$50,000/$150,000	35%	35.5%
$100,000/$300,000	57.5%	58.5%

Deductible Applies to both Indemnity and Loss Adjustment Expense — Credit

Deductible	Physician	Surgeon
$25,000/$75,000	35%	34%
$50,000/$150,000	50%	49%
$100,000/$300,000	72.5%	72.5%

B. On group policies the total amount an insured may pay for a deductible may be capped. Pricing will vary depending on experience, the number of health care providers, and the cap selected. Refer to underwriting.

SUBJECT: CLINICS	
LINE OF COVERAGE: HEALTH CARE PROVIDER	
GUIDELINE NUMBER: UW-35	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

A. PPIC must insure all physicians in the clinic.

B. The clinic cannot provide overnight patient stays and must meet all company requirements.

C. Limits equal to the limits provided for the physician are available to the clinic, on a separate policy (use form CP-101). All physicians utilizing the clinic must carry limits equal to or greater than the limits available to the clinic and proof of coverage.

D. To determine the rating for the clinic, (A) use 10% of the total physicians premium divided by the total number of patients expected in the clinic that year, (b) add 1.4% of a class 1 fully mature physician rate at the limits purchased to allow for employees, and (c) multiply the sum by 100. The total is the rate per 100 outpatient visits.

EXAMPLE:

Total premium of all physicians in clinic: $35,000 x 10% = $3,500
Total number of patient visits expected: 10,000

Physician charge per patient = $3,500 10,000 = $.35
$.35 x 100 = $35.00 per 100 visits

PLUS

Class 1 physician mature rate (at policy limits): $5,000
Employee Charge = 1.4% x 5,000 = $70.00 per 100 visits

CLINIC CHARGE PER 100 VISITS =

$35.0 + $70.00 = $105.00 per 100 visits
10,000 visits = 100 x $105.00 = $10,500

E. Long term treatment clinic (i.e. dialysis, etc.) are rated per 100 outpatient visits:
1. California: 3% of Class 1 rate
2. All other states 1% of Class 1 rate

F. Reporting form endorsement is available. If all professionals of the clinic purchase tail coverage, the clinic shall then be entitled to purchase tail coverage by giving the Company written notice within 30 days of its intent to purchase, and paying the appropriate premium. If all health care providers do not purchase tail coverage, the clinic is not eligible for tail coverage.

G. If no prior acts is provided to the clinic or to any health care provider in the clinic, the extended reporting period premium may be waived. The account would be written at fully mature rates at the inception of the program with PPIC. Any new health care providers added to the clinic in the future will not have prior acts provided. The clinic must develop $250,000 in annual premium and be approved by the Underwriting Department prior to offering this option to an account.

SUBJECT: ACCELERATED REPORTING	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-36	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. A free tail may be provided for those who would not otherwise qualify because they have less than 5 years to work before retirement. This situation occasionally occurs when a group of physicians is considering PPIC and certain members fall into the description described above. The following criteria must be met:
   1. The insured anticipates retirement from his or her profession in less than 5 years,
   2. The insured has attained age 55, and
   3. The insured has a claims-made coverage with the company in a group practice.

   The total number of insureds, within a group practice, that may qualify for the Accelerated Reporting Endorsement may not exceed a ratio of 1 in 5.

B. Extended reporting period coverage would be provided to the corporate entity also.

C. Refer to Underwriting for prior approval.

SUBJECT: RETIRED VOLUNTEER PHYSICIANS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-37	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. This program is available in Nebraska, Colorado, and Texas only.

B. This program is for former physician policyholders of PPIC that are retired and have valid reporting endorsements. These physicians must work without remuneration. No coverage will be provided for any obstetrical, prenatal, invasive or surgical procedures of any type.

C. Coverage may be written on an individual basis only.

D. The physicians should have a valid, current medical license.

E. The maximum allowable number of hours worked per week is 20.

F. Rates apply on a per person basis and appear below. The rates apply regardless of policy term and regardless of the number of years the retroactive date precedes the policy expiration date.

Senior Volunteer Physician – No Surgery	All Number of Years
80579	$100.00

1) No premium discounts are allowable under this program.
2) No pro rata factors apply to this program.
3) A policy writing minimum premium applies to this program.

G. Partnership coverage and employee coverage is not available under this program.

H. The physicians must sign the supplemental application verifying they are doing no obstetrical, prenatal, invasive or surgical procedures.

I. These policies are not eligible for retrospective premium returns.

J. No premium payment plan is available.

K. The limits of liability are $100,000 each medical incident and $200,000 annual aggregate. Limits of liability may not be increased or decreased under this program. (200,000/600,000 in Nebraska only.)

L. Locum tenens provisions do not apply to this program.

M. Employees as additional insured coverage is not permitted under this program.

N. The reporting endorsement will be issued at no charge under this program. The physician must be retiring completely from this program.

SUBJECT: PAYROLL EMPLOYEES	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-38	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

A. Shared Limits of Liability for Payroll Employees:

1. Coverage is provided at no charge to the insured physician for his/her liability for the supervision or the acts of payroll employees.
2. Payroll employees are additional insureds under the policy (except physicians, surgeons, certified registered nurse anesthetists, physician or surgical assistants, nurse midwives, podiatrists, and dentists).
3. The excluded payroll employees shown in 2. above may be added for an additional charge. Refer to B below.
4. Payroll employees as additional insureds have coverage restricted to professional acts done as an employee of our insured. There is no coverage for any independent work of the payroll employee insured.
5. Payroll employees will be added to a corporation policy. If the insured is a sole proprietor, the employees may be added to the sole proprietor's policy.
6. Limits of liability are always shared with the corporation, or physician. For separate limits see B. below.
7. Volunteers will be considered as a payroll employee provided that they are not excluded in 2. above.
8. No additional premium is charged.
9. The extended reporting period for the policy to which the payroll employee is attached governs the tail coverage for all payroll employees.

B. Separate Limits of Liability for Payroll Employees and Excluded Payroll Employees

1. Coverage is provided at no charge to the insured physician for his/her liability for the supervision or the acts of all employees.
2. Payroll employees will be endorsed as an additional insured under the policy
3. Payroll employees as additional insureds have coverage restricted to professional acts done as an employee of our insured. There is no coverage for any independent work of the payroll employee insured.

SUBJECT: PAYROLL EMPLOYEES (Continued)	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-38	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

4. Payroll employees will be added to a corporation policy. If the insured is a sole proprietor, the payroll employees may be added to the sole proprietor's policy.
5. A separate limit of liability will be provided to each payroll employee in which a premium is collected.
6. The premium is determined as follows:
   a. Determine the at limits rates for a class 1 physician, at the same "claims made" step as the physician the payroll employee does the majority of their work for.
   b. Based on the specialty of the employee, determine the correct code number and rate percentage. The code # and rate percentage are shown on the following page.
   c. Multiply the percentage determined by the rate.
7. Minimum premium to add a payroll employee is $100 per employee.
8. The para-professional employee shall have the option to purchase extended reporting period coverage for the policy to which the coverage is attached.

Code	Specialty Description	% of Class 1 Rates filed on State Rate Pages
	Dentists	Refer to Underwriting
	Nurse:	
87907	Anesthetist	
	a. Supervised by Surgeon	1.50
	b. Supervised by Anesthesiologists	.75
87908	c. Unsupervised	2.00
87910	Midwife	1.75
	Physician	As shown in Classification Table
	Employed Physician	0.85 of practicing specialty as shown in the Classification Table
87920	Physician Assistant	.25
87921	Podiatrist (surgery)	2.50
87922	Podiatrist (no surgery)	1.75
	Surgeon	As shown in Classification Table
87924	Surgical Assistant	.60
87998	All Other	Refer to Underwriting

- If more than two CRNA's are supervised by one anesthesiologist, refer to Underwriting for rating.

MISCELLANEOUS PROFESSIONALS – PER EMPLOYEE

Description	**Class Code**	**Relativity**
Health Sciences – Physicist/Biologist	90101	0.15
Chiropractor	80410	0.60
Chiropractor – Employed	80411	0.25
Chiropractor – Assistant	90304	0.25
Laboratory Services – Supervisor/Director	90401	0.075
Laboratory Services – Medical Technician	80711	0.05
Laboratory Services – X-ray Technician	80713	0.05
Laboratory Services – EEG/EKG/Ultrasound Tech.	90405	0.075
Dietician or Nutritionist	87903	0.075
Midwife Assistant	91402	0.50
Nursing Services – Nurse	80998	0.025
Nursing Services – Aide/Homemaker	91504	0.02
Nursing Services – Student Nurse Anesthetist	91509	0.40
Nursing Services – RN Anesthetist	91510	1.30
Occupational Therapist	91601	0.60
Occupational Therapist – Assistant	91602	0.35
Optician	87916	0.075

Optometrist	80994	0.075
Optometrist – Employed	80944	0.025
Optometry-Assistant/Technician	91802	0.15
Opthamalogic Technician	87926	0.10
Orthotics/Prosthetist – Fitting Only	91901	0.50
Prosthetist	87927	0.75
Pharmacist	59112	0.10
Pharmacist Assistant	92002	0.075
Physical Therapist – Owner	80995	0.15
Physician Therapy-Assistant/Aide/Technician	92102	0.05
Physical Therapist – Employed	92103	0.075
Physician Extender – Nurse Practitioner	92201	0.40
Physician Extender-Phys/Surg/Anesth. Assistant	92202	0.50
Physician Extender – Perfusionist	92203	1.25
Psychologist	92401	0.35
Respiratory Therapist	92601	0.50
Respiratory Therapist – Aide/Assistant/Tech	92602	0.35
Social Worker	87905	0.10
Health Services NOC – Paramedic/EMT	93105	0.25
Health Services NOC – Medical Office Assistant	93106	0.035
Health Services NOC – Operating Room Technician	93107	0.075
Dentist – Hygienist	93201	0.10
Dentist – NOC	93202	0.60
Dentistry – Oral Surgeon	80210	Class 5
Dental Anesthesia	93211	2.00
Dentistry – Orthodontist	93212	0.60
Dentistry – Pedodontist	93213	0.60
Dentistry – Periodontist	93214	0.60
Dentistry – Prosthodontist	93215	0.60
Dentistry – Endodontist	93216	0.60
Dentistry – Oral Pathologist	93217	0.60
Dentistry – Public Health	93218	0.60
Dentistry – AAOMS Member	93219	1.50
Dentistry – Other than Oral Surgeons	93220	1.50
X-Ray Therapy	80714	0.025
Chiropodist	80993	0.075
Chiropodist – Employed	80943	0.025
OR Technician	87914	0.35
Scrub Nurse	87912	0.35

SUBJECT: SLOT-RATED GROUP PROGRAM	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-39	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

A. These rating programs are available to those facilities that tend to have a constant number of Full Time Equivalencies (FTE's), with high health care provider turnover.

B. Prior to a slot-rated program being bound, the insured must sign a written agreement indicating the entity will purchase tail coverage from PPIC or obtain prior acts coverage from another carrier. If prior acts coverage is obtained, the new carrier must hold PPIC harmless for certificates of insurance regarding tail coverage that were issued to prior occupants of the slot.

C. The policy provides coverage for all previously terminated and all current health care providers who are scheduled. Only if the program or a slot is terminated will a reporting endorsement be required to cover all past and present individuals.

D. "Slots" (or positions) will be used to determine the exposure base. A "slot" is based on an average of a 50 hour work week for one or more part-time health care providers. Slots may be based on full time equivalent of 50 hours (FTE) if more than one health care provider fills the "slot" during a work week. (A health care provider working full time occupies a "slot" regardless of the number of hours worked.)

E. If .50 or less of a slot is the hours contemplated, round the slot down. If .51 or more of a slot is the hours contemplated, round the slot up. A minimum of one slot is required if any health care provider is working in a particular specialty.

F. Rating for the claims made process will reflect the retroactive date of the slot.

G. RESIDENTS AND INTERNS: Rating for the claims made process will reflect the retroactive date of the program or of the new slot.

H. If a slot remains empty for an extended period of time (90+ days), it will be closed and tail coverage must be purchased. The first slot opened is the first slot closed for rating purposes.

I. PPIC will not offer prior acts coverage on a slot-rated program.

SUBJECT: NON-SLOT RATED GROUP PROGRAM	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-40	
EFFECTIVE DATE: 07/01/99	REVISION DATE: 07/01/99

A. A group of health care providers may be placed on a MP-101 policy without using slot rating. This is the equivalent of one health care provider to one slot.

B. If a health care provider discontinues coverage with PPIC, the health care provider must either purchase tail coverage or obtain prior acts coverage from the new carrier.

C. Prior acts coverage is available upon review and acceptance of a completed application.

D. Payroll employees are not included in this policy. If coverage is desired for payroll employees, a separate corporate policy must be issued. Use guideline UW-37.

SUBJECT: CLASSIFICATION TABLE	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-41	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

Classification	No Surgery	Minor Surgery	Major Surgery
Aerospace Medicine	(1) 80230	-	-
Allergy	(1a) 80254	-	-
Anesthesiology This classification applies to all general practitioners or specialists who perform general anesthesia or acupuncture anesthesia	-	-	(5a) 80151
Broncho-Esophagology	-	-	(3) 80101
Cardiovascular Disease	(1) 80255	(2) 80281	(6) 80150
Dermatology	(1a) 80256	(2) 80282	-
Diabetes	(1) 80237	(2) 80271	-
Emergency Medicine This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital, or rescue facility.	(4) 80102		(5) 80157
Endocrinology	(1) 80238	(2) 80272	(3) 80103
Family Physicians or General Practitioners – including obstetrical procedures	-	(3) 80421	(4) 80117
Family Physicians or General Practitioners – no obstetrical procedures	(1) 80420	(2) 80423	(4) 80117
Forensic Medicine	(1a) 80240	-	-
*CO, DE, IA, LA, MD, and NE Gastroenterology	(1) 80241	(2) 80274	(3) 80104

General Preventive Medicine	(1) 80231	-	-
Geriatrics	(1) 80243	(2) 80276	(3) 80105
Gynecology	(1) 80244	(2) 80277	(5) 80167
Hematology	(1) 80245	(2) 80278	-
Hypnosis	(1) 80232	-	-
Infectious Diseases	(1) 80246	(2) 80279	-
Intensive Care Medicine This classification applies to any general practitioner or specialist employed in an intensive care hospital unit.	(2) 80283	-	-
Internal Medicine	(1) 80257	(2) 80284	-
Laryngology	(1) 80258	(2) 80285	(5) 80106 (4) *
Legal Medicine	(1a) 80240	-	-
Neoplastic Diseases	(1) 80259	(2) 80286	(3) 80107
Nephrology	(1) 80260	(2) 80287	(3) 80108
Neurology – including child	(1) 80261	(2) 80288	(8) 80152
Nuclear Medicine	(1) 80262	-	-
Nutrition	(1) 80248	-	-
Occupational Medicine	(1) 80233	-	-
Ophthalmology	(1) 80263	(2) 80289	(3) 80114 (2) *
*CO, DE, IA, LA, MD, NE Otology	(1) 80264	(2) 80290	(5) 80158 (4) *
Otorhinolaryngology	(1) 80265	(2) 80291	(5) 80159 (4) *

Pathology	(1a) 80266	(2) 80292	-
Pediatrics	(1) 80267	(2) 80293	-
Pharmacology	(1) 80234	-	-
Physiatry	(1) 80235	-	-
Physician Medicine and Rehabilitation	(1) 80235	-	-
Physicians – This is a N.O.C. classification	(1) 80268	(2) 80294	-
Physicians – Major invasive procedures – This classification applies to all general practitioners or specialists except those performing major surgery, anesthesiology, or acupuncture anesthesiology, who perform any of the following medical techniques or procedures: • Acupuncture – other than acupuncture anesthesia • Angiography • Arteriography • Catheterization – arterial, cardiac or diagnostic – other than (1) the occasional emergency insertion of pulmonary wedge, pressure recording catheters or temporary pacemakers, (2) urethral catheterizations, or (3) umbilical cord catherterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen. • Cryosurgery – other than use on benign or pre-malignant dermatological lesions.	(2) 80422	-	-

Listing continued on next page

*CO, DE, IA, LA, MD, NE

- Discograms
- Lasers-used in therapy
- Lymphangiography
- Mylegraphy
- Phlebography
- Pneumoencephalography
- Radiation therapy
- Shock therapy

Physicians – Minor invasive procedures – This classification applies to all general practitioners or specialists, except those performing major surgery, anesthesiology, or acupuncture anesthesiology, who perform any of the following medical techniques or procedures: • Colonoscopy • ERCP (endoscopic retrograde cholangiopancreatography) • Needle biopsy – including lung and prostrate, but not including liver, kidney, or bone marrow biopsy. • Pneumatic or mechanical esophageal dilation (not with bougie or olive) • Radiopaque Dye – injections into blood vessels, lymphatics, sinus tracts of fistulae (not applicable to Radiologists Code 80280)	(2) 80443	-	-
Psychiatry – including child	(1a) 80249	-	-
Psychoanalysis	(1a) 80250	-	-
Psychosomatic Medicine	(1a) 80251	-	-
Public Health	(1a) 80236	-	-
Pulmonary Diseases	(1) 80269	-	-
*CO, DE, IA, LA, MD, NE Radiology – diagnostic – Minor surgery includes radiopaque dye injections into blood vessels, lymphatics, sinus tracts, or fistulae	(1) 80253	(2) 80280	-

Rheumatology	(1) 80252	-	-
Rhinology	(1) 80247	(2) 80270	(5) 80160 (4) *
Surgery – abdominal	-	-	(5) 80166
Surgery – assist only	-	-	(4) 80445
Surgery – cardiac	-	-	(6) 80141
Surgery – colon and rectal	-	-	(3) 80115
Surgery – general – This is a N.O.C. classification. This classification does not apply to any general practitioners or specialists who occasionally performs major surgery	-	-	(5) 80143
Surgery – hand	-	-	(5) 80169
Surgery – head and neck	-	-	(5) 80170
Surgery – neurological	-	-	(8) 80152
Surgery – obstetrics	-	-	(7) 80168
Surgery – obstetrics/gynecology	-	-	(7) 80153
Surgery – orthopedic	-	-	(6) 80154
Surgery – plastic – This is a N.O.C. classification	-	-	(5) 80156
Surgery – plastic – Otorhinolaryngology	-	-	(5) 80155
Surgery – thoracic	-	-	(6) 80144
*CO, DE, IA, LA, MD, NE Surgery – traumatic	-	-	(6) 80171
Surgery – urological	-	-	(3) 80145
Surgery – vascular	-	-	(6) 80146

Urgent Care Physicians – This classification applies to any general practitioner or specialist providing immediate care in an outpatient clinic advertised as urgent care, urgicare, etc., but not involving emergency practice. Similar practice in a hospital setting or one that accepts ambulance service shall be considered emergency medicine.	(1) 80424	-	-

*CO, DE, IA, LA, MD, NE

SUBJECT: PROCEDURE LISTING	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-42	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

The attached listing contains commonly asked about procedures. Several of the procedures indicate a range the classification could fall in. The final determination of these procedures is dependent on the overall practice of the physician.

Acupuncture	Class 2
Adolescent patients	Class 1
Allergy testing	Class 1
Anesthesia – Spinal	Refer to VP-Underwriting. Needs rated up from 5a
Angiography	Class2
Angioplasty – Coronary/Stints	Class 2 w/25% debit
Angioplasty – All Other	Class 2
Assisting in the performance of surgery on own patients	Class 2 or 3 (minor surgery)
Assisting in the performance of surgery on patients other that own	Class 4 (major surgery)
Arterial, cardiac or other diagnostic catheterization (includes insertion of cardiac pacemaker). This does not apply to Swanz-Ganz, umbilical cord or urethral catheterization, or arterial line in a peripheral vessel. (Swanz-Ganz should not be performed by FP's – should be cardiologists or internal medicine only.	Class 2
Arteriography	Class 2
Audiogram	Class 1
Bone Marrow Transplants	Class2
Carpal Tunnel Injections	Borderline Class 1 or 2
Cervical conization	Class 2
Chemobrasion	Class2
Circumcision	Class 1 or 2 (depends on what else doing)
Closed reduction of fractures of the extremities, scapula, clavicle, and ribs requiring closed manipulation	Class 2
Colposcopy	Class 2 (borderline 1)
Colonoscopy	Class 1
Cryosurgery	Class 2

D&C	Class 2
Dermabrasion	Class2
DEXA scans (bone density imaging test)	Class 1
Diagnostic/therapeutic D&C	Class 2
Diagnostic Spinal Tap	Class 1
Diet/Weight Counseling	Class 1
Digital amputation	Class 2
EGD (esophago-gastro-duodenoscopy) (upper GI endoscopy)	Class 2
Electroshock therapy	Class2
Electroencephalography, Electroneuromyography, or Evoiced potentials	Class 1
Endocervical polyp removal	Class 1
Endometrial biopsies	Class 1 or 2 (what else doing i.e. lot's of gyn?)
Endoscopic procedures – bronchoscopy, colposcopy, diagnostic cystoscopy, gastoscopy and diagnostic laparscopy	Class 2
ERCP (endoscopic retroagrade cholangio-pacreatography)	Minor surgery (borderline major); Must review training.
Event Monitoring	Class 1
Excisional biopsy	Class 1
Extraocular surgery (includes surgery on cysts and lids)	Class 2
Flex Sigmoidoscopy	Class 1
Hair Transplantation	Class 2
Intervententional radiology such as embolization, percutaneous transluminal angioplasty, percutaneous nephrostomy and other drainage procedures.	Class 2
IUD insertion	Class 1
Joint injection	Class 1
Laryngoscopy	Class 1
Liquid nitrogen cryotherapy	Class 1
Lumbar puncture	Class 1
Lymphangiography	Class 2
Myelography	Class 2 if FP, Class 1 if radiologist
Needle biopsies of breast, lung, prostate	Class 2
Needle biopsies of liver, kidney, and bone marrow	Class 1
Neonatal	Class 2
Office Splinting	Class 1
Paracentesis	Class 1
Paronychia, I&D (puss pocket)	Class 1
Pediatrics – no surgery – no neonatal	Class 1

Pediatrician attending C-Sects	Must have PALS
Pericardiocentesis	Class 2
Pneumatic esophageal dilation for achalasia	Class 2
Pneumoencephalography	Class 2
Pulmonary Function	Class 1
Punch biopsy	Class 1
Radiopaque Dye Injections	Class 2
Radiation Therapy	Class 2
Rheumatology	Class 1
Sports Medicine patients	Class 1
Stress Testing	Class 1
Sutures	Class 1
Therapeutic radiology, deep (includes radium implants)	Class 2
Thoracentesis	Class 2 at least
Toenail removal	Class 1
Transplants	Class 6 or 7 (Training, how many done, age, etc.)
Treadmill test	Class 2
Trigger point injections	Class 1
Urgent Care	Class 1 or 3 dependent on state quoted in
Vasectomy	Class 2

SUBJECT: TERRITORIAL DEFINITIONS AND FACTORS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-43	
EFFECTIVE DATE: 01/01/2009	REVISION DATE: 01/01/2009

Illinois Territorial Definitions

TERRITORY 1 Territory Factor: 0.800
The following Counties: Champaign, Macon, Sangamon

TERRITORY 2 Territory Factor: 0.550
The following Counties: Coles, DeKalb, LaSalle, Ogle, Randolph, Winnebago

TERRITORY 3 Territory Factor: 1.000
The following Counties: Cook, Madison, St. Clair

TERRITORY 4 Territory Factor: 0.900
The following Counties: DuPage, Kane, McHenry

TERRITORY 5 Territory Factor: 0.900
The following Counties: Jackson, Vermillion

TERRITORY 6 Territory Factor: 0.550
The following Counties: Kankakee

TERRITORY 7 Territory Factor: 0.900
The following Counties: Lake

TERRITORY 8: Territory Factor: 0.550
Remainder of State

TERRITORY 9 Territory Factor: 1.000
The following Counties: Will

* Independent Cities within the county described above are also included in the territory designated.

SUBJECT: INCREASED LIMIT FACTORS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-44	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

The following multipliers will apply to the Company's 100/300 Mature Claims-Made base rates for Physicians not performing major surgery in classes 1 through 4:

Limits ($000s)	Factor
100/300	1.000
200/600	1.270
250/750	1.370
500/1,500	1.760
1,000/3,000	2.200
2,000/4,000	2.690

The following multipliers will apply to the Company's 100/300 Mature Claims-Made base rates for Physicians performing major surgery in classes 5A through 8:

Limits ($000s)	Factor
100/300	1.000
200/600	1.310
250/750	1.430
500/1,500	1.900
1,000/3,000	2.480
2,000/4,000	3.030

Actuarial equivalents apply to all other limits not specifically shown.

SUBJECT: CLASS FACTORS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-45	
EFFECTIVE DATE: 01/01/2009	REVISION DATE: 01/01/2009

Class Factors

Class	Factor
1A	0.800
1	1.000
2	1.500
3	1.850
4	2.550
5A	1.400
5	3.600
6	4.250
7	5.700
8	8.000

SUBJECT: CLAIMS-MADE FACTORS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-46	
EFFECTIVE DATE: 01/01/2009	REVISION DATE: 01/01/2009

Claims-Made Factors

The following multipliers will apply to the Company's $100,000/$3,000,000 mature claims-made base rates:

Years Retroactive Date Precedes Policy Expiration	Factor
1	0.240
2	0.520
3	0.810
4	0.920
5 or more	1.000

SUBJECT: BASE RATES BY TERRITORY	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-47	
EFFECTIVE DATE: 01/01/2009	REVISION DATE: 01/01/2009

$100,000/$300,000 Mature Claims-Made Base Rates

Classification	Territory 1	Territory 2, 6, 8	Territory 3, 9	Territory 4, 5, 7
Class 1A	$6,878	$4,729	$8,598	$7,738
Class 1	8,598	5,911	10,747	9,672
Class 2	12,896	8,866	16,120	14,508
Class 3	15,906	10,935	19,882	17,894
Class 4	21,924	15,073	27,405	24,664
Class 5A	12,037	8,275	15,046	13,541
Class 5	30,951	21,279	38,689	34,820
Class 6	36,540	25,121	45,675	41,107
Class 7	49,006	33,692	61,258	55,132
Class 8	68,781	47,287	85,976	77,378